DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-945 (Rev. 7-03)

STATE OF WISCONSIN

CHECK ONE
❑ INITIAL license
❑ BIENNIAL report

ADULT FAMILY HOME LICENSE APPLICATION / REPORT

Completion of this form is required by s. 50.033(2m), Wis Stats., and ss. HFS 88.03(2)(a), (b) and (4)(b), Wis. Adm. Code. Failure to complete this form accurately may result in licensure denial and/or delay in processing. Personal information collected on this form will be used for licensure and for no other purpose. Send the completed form, with attachments listed below, to your Bureau of Quality Assurance Regional Office. Contact that office if you have questions about completion of this form.

THE FOLLOWING ITEMS MUST BE SUBMITTED

- Certificate of liability insurance coverage HFS 88.04(4)(a)
- Documentation of home owners or renters insurance HFS 88.04(4)(b)
- Program Statement HFS 88.03(2)(b)1.
- License Fee s. 50.033(2), Wis. Stats.
- Check payable to: Division of Disability and Elder Services

The licensee is responsible for notifying the Bureau of Quality Assurance, in writing, of any change in the information provided on this application / report.

Name – Adult Family Home		Telephone Number ( )
Home Street Address	Fire Number	County
Home Mailing Address (if different from street address, e.g., PO Box)		
City	State	Zip Code
Provide specific directions to the facility from the closest major highway		

Name - Licensee	Birth Date	Telephone Number ( )
Name - Individual in Charge Daily		Telephone Number ( )

Is the person above the one you want to receive all mailings? ☐ Yes ☐ No
If "NO" identify the individual to whom legal mailings are to be sent:

Name	Telephone Number ( )
Mailing Address	
City / State / Zip Code	

Total Resident Capacity	☐ All Female ☐ All Male ☐ Both	Does the Adult Family Home have a contract with a county human services or social services department to serve Medicaid waiver eligible residents? ☐ Yes ☐ No

PLEASE CHECK THE BOX(ES) THAT BEST DESCRIBE YOUR RESIDENTS

- ☐ AA Advanced aged (60+ years)
- ☐ ALZ Irreversible dementia/Alzheimer's
- ☐ DD Developmentally Disabled (DD)
- ☐ MH Emotionally disturbed/Mental illness
- ☐ ADA Alcohol/Drug dependent
- ☐ PD Physically disabled
- ☐ PWC Pregnant women who need counseling
- ☐ CC Correctional clients
- ☐ TI Terminally ill
- ☐ TBI Traumatic brain injury
- ☐ ADS Persons with acquired immunodeficiency syndrome (AIDS)

LICENSEE INFORMATION

☐ Individual
☐ Married Couple

FOR PROFIT ORGANIZATION
☐ Corporation
☐ Partnership
☐ Limited Liability Corp.

NON-PROFIT
☐ Corporation
☐ Church
☐ Limited Liability Corp.
☐ Other _____

GOVERNMENT
☐ State
☐ County
☐ Other _____

Licensee Name - Individual or Corporation (legal entity)	Name - Owner or President	
Mailing Address		Telephone Number ( )
City	State	Zip Code

THE LICENSEE OWNS THE:

OPERATION	BUILDING
☐ Yes ☐ No	☐ Yes ☐ No

Does the licensee **at this location** currently hold another type of license or certification? ☐ Yes ☐ No
If "yes," identify the type of license or certification from the following list:

LICENSE TYPE	CERTIFICATION TYPE	REGISTRATION TYPE
☐ Foster Home (children) ☐ Group Foster Home (children) ☐ Residential Care Center for Children and Youth ☐ Shelter Care (children) ☐ Adult Family Home ☐ Nursing Home ☐ Hospital ☐ Community Based Residential Facility ☐ Day Care Center (family or group) ☐ Other _____	☐ Alcohol and Other Drug Abuse Program ☐ Mental Health Program ☐ Adult Day Care ☐ Certified Residential Care Apartment Complex ☐ Other _____	☐ Residential Care Apartment Complex

Have you ever operated a residential facility, health care facility or a day care program for adults or children in Wisconsin or in any other state?
☐ Yes ☐ No

If yes, provide the name, address and telephone number of the facility/program:

Was the facility/program licensed, certified or otherwise regulated by any government or private agency?
☐ Yes ☐ No

If yes, provide the name, address, and telephone number of that agency:

Have you ever had any license, certification or governmental approval to operate a facility/program denied, revoked, suspended or not renewed?
☐ Yes ☐ No

If yes, specify the type of license, certification or approval affected, in which state the action occurred, which agency took the enforcement action, and the name, address, telephone number and type of facility/program that was affected:

Date of Action: _____

What are the minimum and maximum monthly fees charged for resident care? If you charge the same fee to all of your residents, indicate the amount as the "MAXIMUM" fee. (Includes fees paid from all sources including government, private agencies, residents and / or resident's family.)

MINIMUM $_____/MONTH MAXIMUM $_____/MONTH

MONTHLY OPERATING EXPENSES

Salary Expenses _____

Lease or Mortgage Expense _____

All Other Expenses _____

TOTAL Monthly Expenses _____

If income from your residents would not be adequate to pay your monthly operating expenses, do you have other sources of funds or income that may be used to continue the operation of the facility for at least a 60-day period? [HFS 88.04(3)]

☐ Yes Check all appropriate areas:

- ☐ Savings or Other Financial Reserves
- ☐ Purchase Contract (County Department)
- ☐ Outside Employment
- ☐ Other (specify) _____
- ☐ Contract or Agreement with Private Non-Profit Agency
- ☐ Loan

☐ No – Explain how you plan to meet the 60-day financial stability requirement (Attach Documentation)

List below the names of all persons, age 10 and over, who live in the facility and are not a resident. HFS 88.03(3)(b)

Last Name, First Name and MI	Relationship to Licensee	Date of Birth

Certain statutory requirements apply as to where and how close Adult Family Homes can be located. Zoning requirements are determined by your local zoning authority. The Bureau of Quality Assurance will notify your local zoning authority of your application. s. 59.97(15)(a), Wis. Stats.

PHYSICAL LOCATION OF FACILITY

☐ City - Aldermanic District, if any: _____ ☐ Township ☐ Village

Name - Municipality / Township	Name - Municipality / Town Clerk

Address - Municipality / Town Clerk (Street / PO Box, City, State and Zip)

Local fire departments have requested knowing where licensed facilities exist. The Bureau of Quality Assurance will send a copy of your licensing letter to your local fire department. Please provide the fire department's name, address and telephone number below:

Name - Local Fire Department	Telephone Number **(NOT 911)** ( )

Address (Street / PO Box, City, State and Zip Code)

THIS APPLICATION / REPORT MUST BE NOTARIZED – SEE THE FOLLOWING PAGE

The licensee is responsible for notifying the Bureau of Quality Assurance, in writing, of any changes in the information provided on this application / report.

I swear or affirm that all statements made in this application / report and any attachments thereto are correct to the best of my knowledge and that I will comply with laws, rules and regulations governing the licensing of Adult Family Homes in Wisconsin.

DATE SIGNED

SIGNATURE (IN FULL) – LICENSEE OR LEGAL DESIGNEE

TITLE (MUST BE OWNER OR BOARD MEMBER)

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY

OF _____, _____

_____ , NOTARY PUBLIC (NOTARY SEAL)

_____ , COUNTY, WISCONSIN

MY COMMISSION EXPIRES _____